SERFF Tracking Number:	*GPML-126557922*	*State:*	*Arkansas*
Filing Company:	*Government Personnel Mutual Life Insurance Company*	*State Tracking Number:*	*45490*
Company Tracking Number:	*59O ADB10*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*SM4/ADB/CIR applications*		
Project Name/Number:	*SM4/ADB/CIR applications/SM4/ADB/CIR applications*		

Filing at a Glance

Company: Government Personnel Mutual Life Insurance Company

Product Name: SM4/ADB/CIR applications	SERFF Tr Num: GPML-126557922	State: Arkansas
TOI: L07I Individual Life - Whole	SERFF Status: Closed-Approved-Closed	State Tr Num: 45490
Sub-TOI: L07I.101 Fixed/Indeterminate Premium - Single Life	Co Tr Num: 59O ADB10	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Linda Bird
	Authors: Linda Boydston, Norma Castillo	Disposition Date: 04/26/2010
	Date Submitted: 04/22/2010	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: SM4/ADB/CIR applications	Status of Filing in Domicile: Authorized
Project Number: SM4/ADB/CIR applications	Date Approved in Domicile: 03/22/2010
Requested Filing Mode: Review & Approval	Domicile Status Comments: Forms approved in the domicile state of Texas.
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 04/26/2010	Explanation for Other Group Market Type:
	State Status Changed: 04/26/2010
Deemer Date:	Created By: Norma Castillo
Submitted By: Linda Boydston	Corresponding Filing Tracking Number:

Filing Description:

This filing contains no unusual or controversial items from normal company or industry standards.

Forms 59O ADB10, 59P CIR10 and SM4CIRA10 described below will be used with the state approved Simplified Issue Whole Life Insurance Policy form (series 58K SIW06).

SERFF Tracking Number:	*GPML-126557922*	*State:*	*Arkansas*
Filing Company:	*Government Personnel Mutual Life Insurance Company*	*State Tracking Number:*	*45490*
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TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
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59O ADB10 - Accidental Death Benefit Rider - The accidental death benefit is a supplemental benefit attached to the base policy which pays a death benefit when the death results from accidental bodily injury which results from an accident independent of disease or bodily infirmity. The benefit runs through attained age 70. Issue Ages: 20-60. Benefit amounts: $3,000-$35,000. Basis of Values: 2001 CSO Mortality Table, Age Last Birthday, Male, Unismoker combined with the 1959 Accidental Death Benefit Table. Reserves are based on the CRVM method. Continuous functions using an interest rate equal to the maximum allowable valuation interest rate in the Standard Valuation Law.

59P CIR10 - Child Insurance Rider - This rider provides a term death benefit in an amount of $1,000 per unit on an insured child. Coverage goes to the child's age 25 or to the earlier Expiry Date(no death benefit until the child is 14 days old). It is convertible at the Insured Child's age 25 to 5 times insured. It can be issued on male/female. Issue ages: 15 days to 17 years inclusive. Benefit amount: $5,000. No Cash Values are provided on this rider. Reserves are based on 2001 CSO Standard Mortality Table with interest at 4.0%. Reserves are calculated for term to age 25 using CRVM with continuous functions.

SM4CIRA10 - Child Insurance Rider Supplemental Application. Form pertains to the Child Insurance Rider. It will be considered as part of the Application for Life Insurance - Part 1 forms described later in this filing description. When used it will be attached and made a part of the policy.

Actuarial Memorandums are included in the filing. Appropriate information regarding (1) effective dates, (2) amount of these riders, (3) premiums, and (4)termination dates will be printed by computer on page 3 (Schedule Page) of the Simplified Issue Whole Life Policy. Specimen Schedule Pages are included. Forms are a new submission. They have not previously been disapproved. They are not intended to supersede a form previously submitted but not yet approved.

Application forms SM45MAR10 and SM420AR10 will be used with both the state approved Simplified Issue Whole Life Insurance Policy forms (series 58K SIW06) and the Graded Death Benefit Whole Life Insurance Policy form (series 58J GDB06), approved in your jurisdiction on 11/01/2006.

SM420AR10 - Application for Life Insurance - Part 1. This application will be used for issue ages 20-49.

SM45MAR10 - Application for Life Insurance - Part 1. This application will be used for issue ages 50-85.

These forms will replace the previously approved application forms (SM420AR,SM450AR), approved in your jurisdiction 11/01/2006. The differences between the previously approved application forms and the ones being submitted in this filing have been highlighted and attached under the Supporting Documentation Tab.

SERFF Tracking Number:	*GPML-126557922*	*State:*	*Arkansas*
Filing Company:	*Government Personnel Mutual Life Insurance Company*	*State Tracking Number:*	*45490*
Company Tracking Number:	*59O ADB10*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*SM4/ADB/CIR applications*		
Project Name/Number:	*SM4/ADB/CIR applications/SM4/ADB/CIR applications*		

These forms are in final print format; however we reserve the right to change the format of the forms due to technological advances.

Company and Contact

Filing Contact Information

Norma Castillo, Regulatory Filing Assistant	anc@gpmlife.com
2211 N.E. Loop 410	800-938-4765 [Phone] 2724 [Ext]
P.O. Box 659567	210-357-6722 [FAX]
San Antonio, TX 78217	

Filing Company Information

Government Personnel Mutual Life Insurance Company	CoCode: 63967	State of Domicile: Texas
2211 N.E. Loop 410	Group Code:	Company Type: LAH
P.O. Box 659567	Group Name:	State ID Number:
San Antonio, TX 78217	FEIN Number: 74-0651020	
(800) 938-4765 ext. 2814[Phone]		

Filing Fees

Fee Required?	Yes
Fee Amount:	$250.00
Retaliatory?	Yes
Fee Explanation:	$50.00 per form filed separately from policy x 5 forms = $250.00
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Government Personnel Mutual Life Insurance Company	$250.00	04/22/2010	35885146

SERFF Tracking Number:	*GPML-126557922*	*State:*	*Arkansas*
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Product Name:	*SM4/ADB/CIR applications*		
Project Name/Number:	*SM4/ADB/CIR applications/SM4/ADB/CIR applications*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	04/26/2010	04/26/2010

SERFF Tracking Number:	*GPML-126557922*	*State:*	*Arkansas*
Filing Company:	*Government Personnel Mutual Life Insurance Company*	*State Tracking Number:*	*45490*
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Product Name:	*SM4/ADB/CIR applications*		
Project Name/Number:	*SM4/ADB/CIR applications/SM4/ADB/CIR applications*		

Disposition

Disposition Date: 04/26/2010
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*GPML-126557922*	*State:*	*Arkansas*
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Project Name/Number:	*SM4/ADB/CIR applications/SM4/ADB/CIR applications*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	Red Line Version		Yes
Supporting Document	Sample SPCB		Yes
Supporting Document	Sample Schedule Page 3		Yes
Form	Accidental Death Benefit Rider		Yes
Form	Child Insurance Rider		Yes
Form	Life Insurance Application - Part 1		Yes
Form	Life Insurance Application - Part 1		Yes
Form	Part 2 - Child Insurance Rider Supplemental Application		Yes

SERFF Tracking Number:	*GPML-126557922*	*State:*	*Arkansas*
Filing Company:	*Government Personnel Mutual Life Insurance Company*	*State Tracking Number:*	*45490*
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TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*SM4/ADB/CIR applications*		
Project Name/Number:	*SM4/ADB/CIR applications/SM4/ADB/CIR applications*		

Form Schedule

Lead Form Number: 59O ADB10

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	59O ADB10	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Accidental Death Benefit Rider	Initial		52.300	59O ADB10.pdf
	59P CIR10	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Child Insurance Rider	Initial		60.200	59P CIR10.pdf
	SM420AR10	Application/Enrollment Form	Life Insurance Application - Part 1	Initial		59.000	SM420AR10.pdf
	SM45MAR10	Application/Enrollment Form	Life Insurance Application - Part 1	Initial		59.000	SM45MAR10.pdf
	SM4 CIRA10	Application/Enrollment Form	Part 2 - Child Insurance Rider Supplemental Application	Initial		59.000	SM4CIRA10-Final.pdf

ACCIDENTAL DEATH BENEFIT RIDER

General Provisions and Definitions.

This rider gives added benefits, and is part of the Policy to which it is attached.

Consideration for it is the application and payment of premiums shown on the Schedule Page of this Policy.

The date this rider takes effect is the Policy Date, or other date shown on the amended Schedule Page of the Policy, if added after the Policy is issued.

We, Us, Our - Means Government Personnel Mutual Life Insurance Company (GPM).

You, Your - Means the Owner of this Policy.

He, His, Him - Means persons of either sex.

What Do We Mean By Accidental Death?

A1 Payment under this rider will be subject to the terms of the Policy and this rider. We will pay the amount of Accidental Death Benefit as part of the Policy's death benefit Proceeds if We receive due proof that:

1) The Insured's death resulted from accidental bodily injury which is the direct result of an accident occurring before the Insured's 70th birthday, independent of disease or bodily infirmity or any other cause and while this rider is in force.

We reserve the right to obtain, at Our expense, an autopsy, unless prohibited by law.

Additional Indemnity Benefits.

A2 There are additional death benefits if accidental death occurs during one of these two events:

a) Accidental death occurred while the Insured was riding as a fare-paying passenger on a public conveyance;

b) Accidental death occurred while the Insured was wearing a seat belt or the Insured was riding in a seat protected by an air bag.

Some Risks Are Not Covered.

A3 We will not pay this benefit if the Insured dies before His first birthday. Nor will We pay if:

1) Death of the Insured is contributed to or caused by any attempt at suicide, or intentionally self-inflicted injury, while sane or insane.

2) Death of the Insured is contributed to or caused by disease or infirmity of mind or body, or medical or surgical treatment for such disease or infirmity.

3) Death of the Insured is contributed to or caused by an infection not occurring as a direct result or consequence of the accidental bodily injury.

4(a) The Insured receives injuries while He was committing a felony or trying to commit one, or while resisting arrest.

4(b) Death of the Insured is contributed to or caused by participation in an illegal occupation or activity.

4(c) Death of the Insured occurs while the proposed Insured is incarcerated.

5(a) Death of the Insured is contributed to or caused by travel in or descent from an aircraft, if the Insured acted in a capacity other than as a passenger.

5(b) Death of the Insured is contributed to or caused by travel in an aircraft or device used for testing or experimental purposes, used for travel beyond the earth's atmosphere.

6) Injuries resulting from war, declared or not, or any act or war or aggression, insurrection, or riot.

7) Death of the Insured is contributed to or caused by:

(a) The Insured's voluntarily being intoxicated, as defined by the jurisdiction where the accident occurred, or under the influence of any drug unless prescribed or administered by a physician and taken in accordance with the physician's instructions;

(b) Poison, gas or fumes, unless a direct result of an occupational accident.

ACCIDENTAL DEATH BENEFIT RIDER - Continued

8(a) Death of the Insured is contributed to or caused by riding or driving an air, land or water vehicle in a race, speed or endurance contest.

8(b) Death of the Insured is contributed to or caused by bungee jumping;

8(c) Death of the Insured is contributed to or caused by rock or mountain climbing; and/or

8(d) Death of the Insured is contributed to or caused by aeronautics (hang-gliding, skydiving, parachuting, ultralight flight, soaring, ballooning and parasailing).

9) Injuries or disease which occur while this rider was not in force, or while the Policy remained in force under any of its Nonforfeiture terms, except disability that results from injury or disease existing at the time this rider was issued if such injury or disease was disclosed in the application.

How and When Benefits Cease.

A4 This rider will terminate:

1) At the Insured's 70th birthday, or when the Policy is surrendered or expires, if earlier; or

2) If You do not pay the premium for the Policy or this rider before the end of the grace period; or

3) If the Policy is continued under its Nonforfeiture terms; or

4) If You write Us to drop this rider.

Termination shall not prejudice the payment of benefits for any accident that occurred while the form was in force.

Can You Continue this Rider?

A5 If the Policy is exchanged, converted or renewed, this rider may be continued in force by the timely payment of premiums. This right is subject to the following limits:

1) This rider may not exceed the lesser of these:

   a) Its original value; or

   b) The Sum Insured under the new Policy.

2) This rider must be available for the new Policy under Our published rules when You ask to change the Policy.

3) This rider will not be in force longer than the new Policy.

Our Right To Contest is Limited.

A6 We cannot contest this rider as to statements made in the application for it after it has been in force during the lifetime of the Insured for two (2) years from its effective date, except for fraud, when permitted by applicable law in the state where the Policy is delivered and/or non-payment of premiums.

If this rider is reinstated, We cannot contest the reinstatement after this rider is again in force during the lifetime of the Insured for two (2) years from the effective date of reinstatement except for fraud, when permitted by applicable law in the state where the Policy is delivered and/or non-payment of premiums.

We will rely on material representations made in the reinstatement application.

Nonforfeiture Values

A7 This benefit rider does not have cash values or loan values.

GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY
(Referred to above as GPM)

C. Alan Ferguson
Secretary

CHILD INSURANCE RIDER

General Provisions and Definitions.

This rider gives added benefits, and is part of the Policy to which it is attached.

Consideration for it is the application and payment of premiums shown on the Schedule Page.

The date this rider takes effect is the Policy Date, or other date shown on the amended Schedule Page, if added after the Policy is issued.

We, Us, Our - means Government Personnel Mutual Life Insurance Company (GPM).

You, Your - means the Owner of this Policy.

He, His, Him - will be taken to mean persons of either sex.

Age - means at any Policy Anniversary, the Age of the Insured Child under this rider at such Insured Child's last birthday. Age is sometimes called Attained Age.

Insured Child - means the Insured's child(ren), stepchild(ren), adopted child(ren), or grandchild(ren) named on the Schedule Page of the Policy to which this rider is attached. Such Insured Child(ren) must live in such Insured's household at the time of application and be over the age of 14 days and under the age of 18 years. Insured Child is sometimes called Insured Children.

What Are the Benefits under this Rider?

C1 This rider provides certain benefits upon death of an Insured Child.

For a benefit to be payable, this rider must be in force on the Insured Child when their death occurs and while coverage is in force.

Death of an Insured Child.

C2 Upon receipt of proof of death of the Insured Child and due proof of the right of the beneficiary to the Proceeds of this rider, We will pay a death benefit in the amount of the Initial Sum Insured shown under this rider on the Policy's Schedule Page for the deceased Insured Child. Payment will be made in this order:

(1) To the Insured, if living; otherwise,

(2) To the estate of the Insured Child upon whose death payment is being made.

C3 For payment to be made, death must occur:

(1) Before the Insured Child's 25th birthday; and

(2) While this rider is in force on such Insured Child.

Can the Insurance Under this Rider be Converted?

C4 The insurance on each Insured Child expiring at His Age 25 may be converted as of such expiry date. These terms and conditions apply:

(1) This rider must be in force for the Insured Child upon His Age 25.

(2) The Policy to which this rider is attached to must be on premium paying status.

(3) The amount of the new Policy cannot exceed five (5) times the Initial Sum Insured under this rider.

(4) Proper written request for conversion must be made and the required premium paid not later than thirty-one (31) days following such expiry date.

Such Conversion will not require evidence of insurability.

C5 Any insurance so converted will be issued at the Age 25 of the Insured Child who is converting coverage. The premium on the new Policy will be the standard class premium then charged by Us. Conversions may be made only to a policy with level death benefits insuring one life on a simplified issue whole life plan in use by Us on the date of the new policy. It shall be subject to amount and other limits in effect at that time. We must consent to adding any accidental death provisions to the new Policy.

Who is the Owner of this Rider?

C6 The Owner of the Policy will be the Owner of this rider. If the Insured is not the Owner, and the Owner dies without naming a contingent owner, ownership shall pass to the Insured.

CHILD INSURANCE RIDER - Continued

Our Right to Contest is Limited.

C7 We cannot contest coverage on an Insured Child after it has been in force during the lifetime of the Insured Child for two (2) years from its effective date, except for fraud, when permitted by applicable law in the state where the Policy is delivered and/or non-payment of premiums. We cannot contest the reinstatement of an Insured Child's coverage after it has again been in force during the lifetime of the Insured Child for two (2) years from its effective date of reinstatement, except for fraud, when permitted by applicable law in the state where the Policy is delivered,and/or non-payment of premiums. We will rely on material representations made in the reinstatement application.

Does Suicide Make A Difference?

C8 If within two (2) years from the effective date of coverage on an Insured Child, such child commits suicide, while sane or insane, We will refund the premiums paid for that Insured Child, and such child's coverage under this rider will then terminate. If applicable, coverage will continue under this rider for remaining living Insured Children as described in this rider.

If the Insured commits suicide as defined in the Policy's Suicide Provision, We will include a refund of premiums paid for this rider in the amount paid under the Policy's Suicide Provision.

What Happens if Age is Misstated?

C9 We will adjust the amount payable if the Age of the Insured Child is misstated. The amount will be that which the premiums would have bought at the correct Age.

Can this Rider Be Reinstated?

C10 this rider can be reinstated if it lapses. We require that You furnish evidence of insurability satisfactory to Us as to all persons upon whose lives insurance will be reinstated. Reinstatement shall then be effective only on those surviving and otherwise insurable. The rules of reinstatement in the Policy apply.

How and When Benefits Cease.

C11 This rider will terminate for each Insured Child:

(1) Upon His Age 25, or when the Policy is surrendered or expires, if earlier; or

(2) If You do not pay the premium for the Policy and each Insured Child, before the end of the grace period; or

(3) If the Policy is continued under its Nonforfeiture terms; or

(4) If You write Us to drop this rider. If multiple Insured Children are present, the names of each Insured Child must be included in the written correspondence.

(5) Upon the death of the Insured, any unearned premiums for this rider will be refunded.

Nonforfeiture Values

C12 This benefit rider does not have cash values or loan values.

GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY

(Referred to above as GPM)

C. Alan Ferguson
Secretary

APPLICATION FOR LIFE INSURANCE - Part 1

GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY ("GPM Life")

2211 N.E. LOOP 410, San Antonio, Texas 78217 • Telephone: (800) 929-4765 (210) 357-2222

www.gpmlife.com

For Ages 20 through 49, Age Last Birthday

Mail Policy to:
❑ Agent
❑ Policyholder

1.Name of Proposed Insured (First, M.I., Last)

2. Sex ❑ Male ❑ Female 3.Birthdate 4.Birthplace

5. US Citizen ❑ Yes ❑ No 6.Social Security # 7. Height 8. Weight

9. Home Address of Proposed Insured City State/Country Zip Telephone Number

Best time to call _____ A.M. _____ P.M. Time Zone: ❑ Eastern ❑ Central ❑ Mountain ❑ Pacific

10. Policy: ❑ SECURE-Mark 4 - WL ❑ SECURE-Mark 4 - GDB
(WL Only) ❑ Accidental Death Benefit - ADB
(WL Only) ❑ $5,000 Child Insurance Rider - CIR (Part 2 Required)

11. Amount Applied for:$

12. Premium Amount: $

13. Premium Mode ❑ Annual ❑ SemiAnnual ❑ Monthly EFT

14. Automatic Premium Loan (if available) ❑ Yes ❑ No

15. Beneficiary Social Security # Relationship
Primary _____
Contingent

16. Proposed Insured's Occupation

17. Owner/Applicant, if other than the Proposed Insured:

Name _____ Social Security # _____ Relationship to Proposed Insured _____ DOB _____

Address:

18. Physician(s) name, address and phone number: _____

19. a. List Life insurance in force on Proposed Insured: Company _____ Issue Year _____ ADB _____

b. Will the policy applied for replace or change any existing life or annuity policy or contract in any company? ❑ Yes ❑ No

20. Has the Proposed Insured used tobacco in any form in the past 12 months? ❑ Yes ❑ No

If questions 21 through 28 are correctly answered "No", the Proposed Insured may be eligible for SECURE-Mark 4 – WL (Whole Life, Full Death Benefit).

	YES	NO
21. a. Is the Proposed Insured currently hospitalized, confined to a nursing home or hospice, receiving or been recommended to receive home health care, kidney dialysis, or oxygen?	❑	❑
b. Has the Proposed Insured ever been diagnosed by a physician as having Congestive Heart Failure or Cardiomyopathy or been told (s)he has less than 12 months to live?	❑	❑
22. In the past 10 years, has the Proposed Insured been diagnosed by or received treatment from a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS); AIDS Related Complex (ARC); or tested positive for the Human Immunodeficiency Virus (HIV), or the antibodies to such virus?	❑	❑
23. Does the Proposed Insured need any assistance performing activities of daily living (ADLs) such as eating, bathing, using the toilet, independently dressing, taking medications, or walking independently without the use of supportive devices?	❑	❑
24. During the past 24 months, has the Proposed Insured been treated or given medical advice by a medical professional, including office visits, medications or surgery for:		
a. Stroke, transient ischemic attack (TIA), heart attack, angina, or any procedure to improve circulation to the heart or brain?	❑	❑
b. Organ transplant or recommendation to have an organ transplant?	❑	❑
c. Melanoma, internal cancer, or leukemia?	❑	❑
d. Alzheimer's disease, dementia, Amyotropic Lateral Sclerosis (ALS), or Parkinson's Disease?	❑	❑
e. Emphysema, liver disease, kidney disease, or kidney failure?	❑	❑
f. Alcohol and/or drug abuse?	❑	❑
g. Diabetes requiring insulin or any diabetic complications including diabetic kidney disease, eye disorder, numbness in hands or feet, diabetic coma, insulin shock, or uncontrolled blood sugars?	❑	❑
25. During the past 5 years, has the Proposed Insured been convicted of a felony, been incarcerated, or been on parole or probation for any offense?	❑	❑

Circle each condition resulting in a "Yes" answer for questions 26 through 28.

26. During the past 12 months, has the Proposed Insured:	YES	NO
a. Been admitted to or confined in a hospital two or more times?	❑	❑
b. Been told by a medical professional that (s)he needs a medical procedure, surgery, hospitalization, or nursing facility care that has not yet been completed?	❑	❑
c. Been confined to a nursing facility or received home health care?	❑	❑
27. During the past 24 months, has the Proposed Insured been treated or given medical advice by a medical professional, including office visits, medications or surgery for:		
a. Seizures or other neurological disorder, Major Depression, Schizophrenia, Psychosis, Bipolar Disorder or other psychiatric disorder?	❑	❑
b. Irregular heart rhythm, enlarged heart, or any other heart disorder?	❑	❑
c. Chronic Obstructive Pulmonary Disease (COPD), or other chronic respiratory disorder (excluding mild asthma requiring occasional inhaler use)?	❑	❑
d. Lupus (SLE), Muscular Dystrophy, Multiple Sclerosis, Amyotropic Lateral Sclerosis (ALS) or other neuromuscular disorder?	❑	❑
e. Diabetes requiring medication other than insulin?	❑	❑
28. During the past 24 months, has the Proposed Insured had a suspended or revoked driver's license or had 3 or more moving violations?	❑	❑

For Home Office Endorsements:	Special Instructions/Requests:

AGREEMENT: I have read this application. I understand the questions and my answers, and I represent that all of the information given in it is true, complete, and correctly written. I understand that any misstatements as to the health or physical condition of the Proposed Insured that are material to the risk assumed may cause any policy issued to become void within the contestable period. It is agreed that:

A. This application, Part 2 of this application if applicable, and any amendments or supplements to it will be relied on by GPM Life as the basis of any policy which may be issued. The signer(s) agree that a complete faxed copy of this document is equivalent to the original.

B. Acceptance of a policy issued on this application will ratify any changes which may be noted in the section for "Home Office Endorsements." Written consent must be obtained for any change in the application, where required by law.

C. Any policy issued by GPM Life, or applied for, shall not take effect unless the full first premium is paid and the policy is delivered to the owner during the lifetime of the Proposed Insured, and all the statements and answers given in the application continue to be true and complete. The Proposed Insured and Owner/Applicant must notify GPM Life of any material change in health or other risk factors taking place before policy delivery.

D. NO AGENT, BROKER OR MEDICAL EXAMINER IS AUTHORIZED TO ACCEPT RISKS OR PASS UPON INSURABILITY, TO MAKE OR MODIFY CONTRACTS, OR TO WAIVE ANY OF GPM LIFE'S RIGHTS, CONDITIONS, OR REQUIREMENTS. ONLY AN AUTHORIZED OFFICER OF GPM LIFE CAN DO THESE THINGS.

BACKUP WITHHOLDING CERTIFICATION: (required to comply with Federal tax law): Under penalties of perjury, I (the proposed owner) certify that (A) my Social Security (Taxpayer Identification) number as shown in the Application is correct, and (B) I am not subject to backup withholding either because I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report interest or dividends, or the IRS has notified me that I am no longer subject to backup withholding. (NOTE: You must cross out item B above if you have been notified by the IRS that you are currently subject to backup withholding.)

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION: I authorize any medical practitioner, hospital, clinic, mental health facility, facility for the treatment of alcohol, drug abuse, or AIDS, Veteran's Administration hospital, other medically related facility, employer, insurer, or its agent, reinsurer, the Medical Information Bureau, Inc. (MIB), government or law enforcement unit, consumer reporting agency, or other insurance support organization having information as to the mental or physical health, occupation, avocation, other insurance, character, habits, driving record, finances, or age of me, to give such information to GPM Life or its reinsurer(s) at any time, including after my death. I further authorize all said sources, except MIB, to give such information to any agent or insurance support organization acting for GPM Life or its reinsurer(s). Any information obtained will be used to determine eligibility for insurance coverage and benefits, and may be released by GPM Life to its reinsurer(s), the MIB, or other persons or organizations performing business or legal services in connection with my application or claim, or as may be otherwise lawfully required. I agree that a photocopy of this form will be as valid as the original. I also agree that this form will be valid for (1) 24 months from the date signed in connection with an application for issuance, reinstatement, or change of an insurance policy, or (2) the duration of a claim for benefits. I know that I, or a person authorized to act for me, may obtain a copy of this form. I acknowledge receipt of notices entitled "Information Practices" and "Medical Information Bureau, Inc." from GPM Life.

WARNING: Any person who knowingly and with the intent to defraud any insurance company, or other person, files an application for insurance or settlement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Proposed Insured's Signature X	Date	City & State Where Application Completed
Owner's/Applicant's Signature (If other than Proposed Insured) X	Date	City & State Where Application Completed

AGENT'S STATEMENT: I HEREBY CERTIFY that the answers given to the foregoing questions in this application are full, complete and true to the best of my knowledge and belief; that I know of no condition affecting the insurability of the Proposed Insured which is not fully set forth herein; that I carefully asked each question as written before recording each answer prior to the application being signed; that the Special Notices regarding Information Practices and the Medical Information Bureau, Inc. were given to the Proposed Insured. I further certify that I have interviewed the Proposed Insured face to face and witnessed the above signature(s): ❑ Photo ID verified Type of ID _____
(REQUIRED)

To the best of your knowledge:	Yes	No
A. Has the Proposed Insured any existing life insurance or annuity policy or contract?	❑	❑
B. Is the insurance applied for intended to replace or change any existing life insurance or annuity policy or contract?	❑	❑

If the answer to A or B is "Yes", attach completed replacement forms if required by your state.

X Writing Agent's Signature	Date	Agent's Name (Please Print)	State / License #	GPM Life Agent #
			/	

RECEIPT FOR PAYMENT

Received from _____ Date _____

the sum of $ _____. The payment is received subject to the conditions below. This receipt does not provide any insurance.

I certify that I have explained all of the terms of this receipt to the Owner(s)/Applicant(s), and Proposed Insured, if different.

_____

Signature of Writing Agent

ALL CHECKS MUST BE MADE PAYABLE TO GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY

This receipt is not valid unless it is signed by an agent of GPM Life. This receipt is not valid unless the amount paid with the application, if paid by check or draft, is honored on first presentation for payment. Any policy issued by GPM Life shall not take effect until the full first premium is paid, the policy is delivered to the owner during the lifetime of the Proposed Insured, the effective date of the policy has arrived, and all the statements and answers given in the application continue to be true and complete. The Proposed Insured and Owner/Applicant must notify GPM Life of any material change in health or other risk factors taking place before policy delivery.

NO AGENT, BROKER OR MEDICAL EXAMINER IS AUTHORIZED TO ACCEPT RISKS OR PASS UPON INSURABILITY, TO MAKE OR MODIFY CONTRACTS, OR TO WAIVE ANY OF GPM LIFE'S RIGHTS, CONDITIONS, OR REQUIREMENTS. ONLY AN AUTHORIZED OFFICER OF GPM LIFE CAN DO THESE THINGS.

NOTICE OF INFORMATION PRACTICES AND NOTICE REGARDING MEDICAL INFORMATION BUREAU, INC.

WRITING AGENT: This special notice must be detached and given to the Proposed Insured.

PROPOSED INSURED: PLEASE RETAIN THIS SPECIAL NOTICE FOR YOUR RECORDS.

INFORMATION PRACTICES: In most cases, the application is the only source of information required about the person(s) proposed for insurance. Occasionally, it is necessary to collect additional, personal information from other sources. Such information may, in some circumstances, be disclosed to third parties without your specific authorization, but only for certain limited purposes which we deem necessary to the conduct of our business. A right of access and correction exists with respect to any personal information we may collect. A notice providing a more detailed description of our information practices and your rights is available upon request.

GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY • San Antonio, Texas 78265

MEDICAL INFORMATION BUREAU, INC: Information regarding your insurability will be treated as confidential. We, or our reinsurer(s), may, however, make a brief report thereon to the Medical Information Bureau, Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734, telephone number (617) 426-3660. Information for consumers about MIB may be obtained on its website at www.mib.com. We, or our reinsurer(s), may also release information in our file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits is submitted.

APPLICATION FOR LIFE INSURANCE - Part 1

GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY ("GPM Life")

2211 N.E. LOOP 410, San Antonio, Texas 78217 • Telephone: (800) 929-4765 (210) 357-2222

www.gpmlife.com

For Ages 50 through 85, Age Last Birthday

Mail Policy to:
❑ Agent
❑ Policyholder

1.Name of Proposed Insured (First, M.I., Last)

2. Sex ❑ Male ❑ Female | 3.Birthdate | 4.Birthplace

5. US Citizen ❑ Yes ❑ No | 6.Social Security # | 7. Height | 8. Weight

9. Home Address of Proposed Insured | City | State/Country | Zip | Telephone Number

Best time to call _____ A.M. _____ P.M. Time Zone: ❑ Eastern ❑ Central ❑ Mountain ❑ Pacific

10. Policy: ❑ SECURE-Mark 4 - WL ❑ SECURE-Mark 4 - GDB ❑ SECURE-Mark 4 - MBWL
(WL Only) ❑ Accidental Death Benefit - ADB
(WL Only) ❑ $5,000 Child Insurance Rider - CIR (Part 2 Required)

11. Amount Applied for:$

12. Premium Amount: $

13. Premium Mode ❑ Annual ❑ SemiAnnual ❑ Monthly EFT

14. Automatic Premium Loan (if available) ❑ Yes ❑ No

15. Beneficiary | Social Security # | Relationship
Primary _____
Contingent

16. Proposed Insured's Occupation

17. Owner/Applicant, if other than the Proposed Insured:

Name _____ Social Security # _____ Relationship to Proposed Insured _____ DOB _____

Address:

18. Physician(s) name, address and phone number: _____

19. a. List Life insurance in force on Proposed Insured: Company _____ Issue Year _____ ADB_____

b. Will the policy applied for replace or change any existing life or annuity policy or contract in any company? ❑ Yes ❑ No

20. Has the Proposed Insured used tobacco in any form in the past 12 months? ❑ Yes ❑ No

If questions 21 through 29 are correctly answered "No", the Proposed Insured may be eligible for SECURE-Mark 4 - WL (Whole Life, Full Death Benefit).

	YES	NO
21. Is the Proposed Insured currently hospitalized, confined to a nursing home or hospice, receiving or been recommended to receive home health care or kidney dialysis, or been diagnosed by a physician as having Alzheimer's Disease, dementia, or Amyotropic Lateral Sclerosis (ALS) or been told (s)he have less than 12 months to live?	❑	❑
22. In the past 10 years, has the Proposed Insured been diagnosed by or received treatment from a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS); AIDS Related Complex (ARC); or tested positive for the Human Immunodeficiency Virus (HIV), or the antibodies to such virus?	❑	❑
23. During the past 5 years, has the Proposed Insured been convicted of a felony, been incarcerated, or been on parole or probation for any offense?	❑	❑
24. Is the Proposed Insured currently receiving or been recommended to receive oxygen?	❑	❑
25. Has the Proposed Insured ever been diagnosed by a physician as having Congestive Heart Failure or cardiomyopathy?	❑	❑
26. Does the Proposed Insured need any assistance performing activities of daily living (ADLs) such as eating, bathing, using the toilet independently, dressing, taking medications, or walking independently without the use of supportive devices?	❑	❑

Circle each condition resulting in a "Yes" answer for questions 27 through 29.

	YES	NO
27. During the past 12 months, has the Proposed Insured:		
a. Been admitted to or confined in a hospital two or more times?	❑	❑
b. Been told by a medical professional that (s)he needs a medical procedure, surgery, hospitalization or nursing facility care that has not been completed?	❑	❑
c. Been confined to a nursing facility or received home health care?	❑	❑
28. During the past 24 months, has the Proposed Insured been treated or given medical advice by a medical professional, including office visits, medications or surgery for:		
a. Stroke, transient ischemic attack (TIA), heart attack, angina, or any procedure to improve circulation to the heart or brain?	❑	❑
b. Organ transplant, or recommendation to have an organ transplant?	❑	❑
c. Melanoma, internal cancer, or leukemia?	❑	❑
d. Parkinson's Disease, seizure, neurological disorder, Major Depression, Schizophrenia, Psychosis, Bipolar Disorder, or other psychiatric disorder?	❑	❑
e. Liver disease, kidney disease, kidney failure, Lupus (SLE) or Amyotropic Lateral Sclerosis (ALS)?	❑	❑
f. Irregular heart rhythm, enlarged heart, or any other heart disorder?	❑	❑
g. Alcohol and/or drug abuse?	❑	❑
h. Diabetes requiring more than 80 units of insulin, or any diabetic complications, including diabetic kidney disease, eye disorder, numbness in hands or feet, diabetic coma, insulin shock, or uncontrolled blood sugars?	❑	❑
i. Emphysema, Chronic Obstructive Pulmonary Disease (COPD), or other chronic respiratory disorder (excluding mild asthma requiring occasional inhaler use)?	❑	❑
29. During the past 24 months, has the Proposed Insured had a suspended or revoked driver's license or had 3 or more moving violations?	❑	❑

For Home Office Endorsements:	Special Instructions/Requests:

AGREEMENT: I have read this application. I understand the questions and my answers, and I represent that all of the information given in it is true, complete, and correctly written. I understand that any misstatements as to the health or physical condition of the Proposed Insured that are material to the risk assumed may cause any policy issued to become void within the contestable period. It is agreed that:

A. This application, Part 2 of this application if applicable, and any amendments or supplements to it will be relied on by GPM Life as the basis of any policy which may be issued. The signer(s) agree that a complete faxed copy of this document is equivalent to the original.

B. Acceptance of a policy issued on this application will ratify any changes which may be noted in the section for "Home Office Endorsements." Written consent must be obtained for any change in the application, where required by law.

C. Any policy issued by GPM Life, or applied for, shall not take effect unless the full first premium is paid and the policy is delivered to the owner during the lifetime of the Proposed Insured, and all the statements and answers given in the application continue to be true and complete. The Proposed Insured and Owner/Applicant must notify GPM Life of any material change in health or other risk factors taking place before policy delivery.

D. NO AGENT, BROKER OR MEDICAL EXAMINER IS AUTHORIZED TO ACCEPT RISKS OR PASS UPON INSURABILITY, TO MAKE OR MODIFY CONTRACTS, OR TO WAIVE ANY OF GPM LIFE'S RIGHTS, CONDITIONS, OR REQUIREMENTS. ONLY AN AUTHORIZED OFFICER OF GPM LIFE CAN DO THESE THINGS.

BACKUP WITHHOLDING CERTIFICATION: (required to comply with Federal tax law): Under penalties of perjury, I (the proposed owner) certify that (A) my Social Security (Taxpayer Identification) number as shown in the Application is correct, and (B) I am not subject to backup withholding either because I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report interest or dividends, or the IRS has notified me that I am no longer subject to backup withholding. (NOTE: You must cross out item B above if you have been notified by the IRS that you are currently subject to backup withholding.)

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION: I authorize any medical practitioner, hospital, clinic, mental health facility, facility for the treatment of alcohol, drug abuse, or AIDS, Veteran's Administration hospital, other medically related facility, employer, insurer, or its agent, reinsurer, the Medical Information Bureau, Inc. (MIB), government or law enforcement unit, consumer reporting agency, or other insurance support organization having information as to the mental or physical health, occupation, avocation, other insurance, character, habits, driving record, finances, or age of me, to give such information to GPM Life or its reinsurer(s) at any time, including after my death. I further authorize all said sources, except MIB, to give such information to any agent or insurance support organization acting for GPM Life or its reinsurer(s). Any information obtained will be used to determine eligibility for insurance coverage and benefits, and may be released by GPM Life to its reinsurer(s), the MIB, or other persons or organizations performing business or legal services in connection with my application or claim, or as may be otherwise lawfully required. I agree that a photocopy of this form will be as valid as the original. I also agree that this form will be valid for (1) 24 months from the date signed in connection with an application for issuance, reinstatement, or change of an insurance policy, or (2) the duration of a claim for benefits. I know that I, or a person authorized to act for me, may obtain a copy of this form. I acknowledge receipt of notices entitled "Information Practices" and "Medical Information Bureau, Inc." from GPM Life.

WARNING: Any person who knowingly and with the intent to defraud any insurance company, or other person, files an application for insurance or settlement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Proposed Insured's Signature X	Date	City & State Where Application Completed
Owner's/Applicant's Signature (If other than Proposed Insured) X	Date	City & State Where Application Completed

AGENT'S STATEMENT: I HEREBY CERTIFY that the answers given to the foregoing questions in this application are full, complete and true to the best of my knowledge and belief; that I know of no condition affecting the insurability of the Proposed Insured which is not fully set forth herein; that I carefully asked each question as written before recording each answer prior to the application being signed; that the Special Notices regarding Information Practices and the Medical Information Bureau, Inc. were given to the Proposed Insured. I further certify that I have interviewed the Proposed Insured face to face and witnessed the above signature(s): ❑ Photo ID verified Type of ID _____
(REQUIRED)

To the best of your knowledge:	Yes	No
A. Has the Proposed Insured any existing life insurance or annuity policy or contract?	❑	❑
B. Is the insurance applied for intended to replace or change any existing life insurance or annuity policy or contract?	❑	❑

If the answer to A or B is "Yes", attach completed replacement forms if required by your state.

X Writing Agent's Signature	Date	Agent's Name (Please Print)	State / License #	GPM Life Agent #
			/	

RECEIPT FOR PAYMENT

Received from _____ Date _____

the sum of $ _____. The payment is received subject to the conditions below. This receipt does not provide any insurance.

I certify that I have explained all of the terms of this receipt to the Owner(s)/Applicant(s), and Proposed Insured, if different.

_____

Signature of Writing Agent

ALL CHECKS MUST BE MADE PAYABLE TO GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY

This receipt is not valid unless it is signed by an agent of GPM Life. This receipt is not valid unless the amount paid with the application, if paid by check or draft, is honored on first presentation for payment. Any policy issued by GPM Life shall not take effect until the full first premium is paid, the policy is delivered to the owner during the lifetime of the Proposed Insured, the effective date of the policy has arrived, and all the statements and answers given in the application continue to be true and complete. The Proposed Insured and Owner/Applicant must notify GPM Life of any material change in health or other risk factors taking place before policy delivery.

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NOTICE OF INFORMATION PRACTICES AND NOTICE REGARDING MEDICAL INFORMATION BUREAU, INC.

WRITING AGENT: This special notice must be detached and given to the Proposed Insured.

PROPOSED INSURED: PLEASE RETAIN THIS SPECIAL NOTICE FOR YOUR RECORDS.

INFORMATION PRACTICES: In most cases, the application is the only source of information required about the person(s) proposed for insurance. Occasionally, it is necessary to collect additional, personal information from other sources. Such information may, in some circumstances, be disclosed to third parties without your specific authorization, but only for certain limited purposes which we deem necessary to the conduct of our business. A right of access and correction exists with respect to any personal information we may collect. A notice providing a more detailed description of our information practices and your rights is available upon request.

GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY • San Antonio, Texas 78265

MEDICAL INFORMATION BUREAU, INC: Information regarding your insurability will be treated as confidential. We, or our reinsurer(s), may, however, make a brief report thereon to the Medical Information Bureau, Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734, telephone number (617) 426-3660. Information for consumers about MIB may be obtained on its website at www.mib.com. We, or our reinsurer(s), may also release information in our file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits is submitted.

Government Personnel Mutual Life Insurance Company
2211 N.E. Loop 410, San Antonio, Texas 78217

PART 2 - CHILD INSURANCE RIDER SUPPLEMENTAL APPLICATION
$5,000 DEATH BENEFIT PER CHILD FOR CHILDREN OR GRANDCHILDREN OF PROPOSED INSURED

(Each Proposed Insured Child must reside in the household of the Proposed Insured.)

ISSUE AGES 15 DAYS – 17 YEARS INCLUSIVE

PROPOSED INSURED CHILD'S			
Name ***(First, Middle, Last)***	**Date of Birth**	**Age Last Birthday**	**Relationship to Proposed Insured**

Health Statement. In the past 24 months, the Proposed Insured Child/Children listed above, have not been diagnosed with, treated for, tested positive for, or been told by a medical professional they have: any form of cancer or leukemia; heart or circulatory disorder; cystic fibrosis; kidney disease; liver disease; diabetes; quadriplegia; multiple sclerosis (MS); seizures; muscular dystrophy; sickle cell anemia; cerebral palsy, cognitive or psychological disorder, chronic respiratory disorder (excluding mild asthma with occasional inhaler use); or attempted suicide.

And, in the past 24 months, the Proposed Insured Child/Children listed above, have not used any illegal, restricted or controlled substance except as prescribed by a medical professional. And, have not been counseled or treated for alcohol or substance abuse or been convicted of a felony, incarcerated or been subject to probation.

Remarks (please note the child's name and any exceptions to the statement above).

_____

_____

I, the Proposed Insured from Part 1, am the parent or grandparent (if legal guardian please attach a copy of guardianship papers) of the Proposed Insured Child/Children and I have read the completed supplemental application. The above representations are true. I understand that all statements made by me shall, in the absence of fraud, be deemed representations and not warranties. I understand that the information on this application will be relied upon to determine insurability and that incorrect information may result in coverage being voided, subject to the rider incontestability provision. I agree that this supplemental application will become a part of any contract of insurance issued as a result of this application.

The Fraud Warning required in the State in which the Application for Life Insurance – Part 1 was signed and dated applies to this Part 2 – Child Insurance Rider Supplemental Application.

Date	Print Name of Proposed Insured from Part 1	Signature of Proposed Insured from Part 1

For Each Proposed Insured Child age 15 and Over			
Print Name	Signature	Print Name	Signature

Date	Agent's Name (please print)	Writing Agent's Signature	State/License #	GPM Agent #

SERFF Tracking Number:	*GPML-126557922*	*State:*	*Arkansas*
Filing Company:	*Government Personnel Mutual Life Insurance Company*	*State Tracking Number:*	*45490*
Company Tracking Number:	*59O ADB10*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*SM4/ADB/CIR applications*		
Project Name/Number:	*SM4/ADB/CIR applications/SM4/ADB/CIR applications*		

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification

Comments:

Attachments:

Readability Certification.pdf

Regulation 49.pdf

Rule and Regulation 19.pdf

Bulletin 15-2009.pdf

Item Status: **Status Date:**

Satisfied - Item: Application

Comments:

Applications filed under Form Schedule Tab

Item Status: **Status Date:**

Satisfied - Item: Red Line Version

Comments:

Attachments:

Redline Comparions-SM420AR to SM420AR10.pdf

Redline Comparison-SM450AR to SM45MAR10.pdf

Item Status: **Status Date:**

Satisfied - Item: Sample SPCB

Comments:

Attachment:

Printed Specimen SPCB - CIR.pdf

SERFF Tracking Number:	*GPML-126557922*	*State:*	*Arkansas*
Filing Company:	*Government Personnel Mutual Life Insurance Company*	*State Tracking Number:*	*45490*
Company Tracking Number:	*59O ADB10*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*SM4/ADB/CIR applications*		
Project Name/Number:	*SM4/ADB/CIR applications/SM4/ADB/CIR applications*		

Item Status: **Status Date:**

Satisfied - Item: Sample Schedule Page 3

Comments:

Attachments:

Specimen SIWL Schedule Page 3 w ADB only.pdf

Specimen SIWL Schedule Page 3 w CIR only.pdf

Specimen SIWL Schedule Page 3 w ADB and CIR.pdf

02AR

ARKANSAS

SUBJECT - Individual Life ___X___ Individual Annuity _____

INSURER - GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY

FORM NUMBER	FLESCH SCORE
59O ADB10	**52.3**
59P CIR10	**60.2**
SM45M10	**59** This form was scored as part of the policy with which it may be used.
SM42010	**59** This form was scored as part of the policy with which it may be used.
SM4CIRA10	**59** This form was scored as part of the policy with which it may be used.

This is to certify that the above referenced form has achieved a Flesch Reading Ease Score, as indicated, and complies with the requirements of Arkansas Stat. Ann. 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Sean Staggs, FSA, MAAA
Assistant Vice President & Associate Actuary

AR certification3

ARKANSAS

SUBJECT - Individual Life ___X___ Individual Annuity _____

INSURER - GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY

FORM NUMBER

59O ADB10
59P CIR10
SM45M10
SM42010
SM4CIRA10

On behalf of Government Personnel Mutual Life Insurance Company, I hereby certify that the company is in compliance with Regulation 49 in that we will issue a Life and Health notice to each policy owner.

Sean Staggs, FSA, MAAA
Assistant Vice President & Associate Actuary

AR certification1

ARKANSAS

SUBJECT - Individual Life ___X___ Individual Annuity _____

INSURER - GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY

FORM NUMBER

59O ADB10
59P CIR10
SM45M10
SM42010
SM4CIRA10

This submission meets the provisions of Rule and Regulation 19, "Unfair sex discrimination in the sale of insurance" as well as all applicable requirements of this Department.

Sean Staggs, FSA, MAAA
Assistant Vice President & Associate Actuary

AR certification2

ARKANSAS

SUBJECT - Individual Life X Individual Annuity _____

INSURER - GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY

FORM NUMBER

59O ADB10
59P CIR10
SM45M10
SM42010
SM4CIRA10

On behalf of Government Personnel Mutual Life Insurance Company, I hereby certify that I have reviewed Bulletin 15-2009 and the form complies with these guidelines.

Sean Staggs, FSA, MAAA
Assistant Vice President & Associate Actuary

Text Comparison

Documents Compared

SM420AR.pdf - Adobe Acrobat Professional

SM420AR10.pdf

Summary

535 word(s) added
442 word(s) deleted
1925 word(s) matched
39 block(s) matched

To see where the changes are, scroll down.

APPLICATION FOR LIFE INSURANCE

GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY ("GPM Life")

2211 N.E. LOOP 410, San Antonio, Texas 78217
Telephone: (800) 929-4765 (210) 357-2222
www.gpmlife.com

Mail Policy to:
☐ Agent
☐ Policyholder

For Ages 20 through 49, Age Last Birthday

1.Name of Proposed Insured (First, M.I., Last)	2. Sex ☐ Male ☐ Female	3.Birthdate	4.Birthplace	5. US Citizen ☐ Yes ☐ No	6.Social Security #	7. Height	8. Weight

9. Home Address of Proposed Insured City State/Country Zip Telephone Number

Best time to call _____ A.M. _____ P.M. Time Zone: ☐ Eastern ☐ Central ☐ Mountain ☐ Pacific

10. Policy: ☐ SECURE-Mark 4 - WL	11. Amount Applied for: $	12. Premium Amount $	13. Premium Mode ☐ Annual ☐ SemiAnnual ☐ Monthly EFT	14. Automatic Premium Loan (if available) ☐ Yes ☐ No

15. Beneficiary Social Security # Relationship
Primary _____
Contingent

16. Occupation

17. Owner/Applicant, if other than the Proposed Insured:
Name _____ Social Security # _____ Relationship to Proposed Insured _____ DOB _____
Address:

18. Physician(s) name, address and phone number: _____

19. a. List Life insurance in force on Proposed Insured: Company _____ Issue Year _____ ADB _____
b. Will the policy you are applying for replace or change any existing life or annuity policy or contract in any company? ☐ Yes ☐ No
20. Have you used tobacco in any form in the past 12 months? ☐ Yes ☐ No

If questions 21 through 29 are correctly answered "No", the Proposed Insured is eligible for SECURE-Mark 4 - WL (Whole Life, Full Death Benefit).

	YES	NO
21. a. Are you currently hospitalized, confined to a nursing home or hospice, receiving or been recommended to receive home health care, kidney dialysis, or oxygen?	☐	☐
b. Have you ever been diagnosed by a physician as having Congestive Heart Failure or Cardiomyopathy or been told you have less than 12 months to live?	☐	☐
22. In the past 10 years, have you been diagnosed by or received treatment from a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS); AIDS Related Complex (ARC); or tested positive for the Human Immunodeficiency Virus (HIV), or the antibodies to such virus?	☐	☐
23. Do you need any assistance performing activities of daily living (ADLs) such as eating, bathing, using the toilet independently, dressing, taking medications, or walking independently without the use of supportive devices?	☐	☐
24. During the past 24 months:		
a. Have you had a stroke, transient ischemic attack (TIA), heart attack, angina, or any procedure to improve circulation to the heart or brain?	☐	☐
b. Have you had or been recommended to have an organ transplant?	☐	☐
c. Had or been treated (including medications or surgery) for melanoma, internal cancer, or leukemia?	☐	☐
25. During the past 24 months, have you had or been treated by a medical professional, including office visits, medications or surgery for:		
a. Alzheimer's disease, dementia, or Parkinson's Disease?	☐	☐
b. Emphysema, liver disease, kidney disease, or kidney failure?	☐	☐
c. Alcohol and/or drug abuse?	☐	☐
d. Diabetes requiring insulin or any diabetic complications including diabetic kidney disease, eye disorder, numbness in hands or feet, diabetic coma, insulin shock, or uncontrolled blood sugars?	☐	☐
26. During the past 5 years, have you been convicted of a felony?	☐	☐
Circle each condition resulting in a "Yes" answer for questions 27 through 29.		
27. During the past 12 months, have you:		
a. Been admitted to or confined in a hospital two or more times?	☐	☐
b. Been told by a medical professional that you need a medical procedure, surgery, hospitalization, or nursing facility care?	☐	☐
c. Been confined to a nursing facility or received home health care?	☐	☐
28. During the past 24 months, have you had or been treated by a medical professional, including office visits, medications or surgery for:		
a. Seizures or other neurological disorder, depression or other psychiatric disorder?	☐	☐
b. Irregular heart rhythm, enlarged heart, or any other heart disorder?	☐	☐
c. Chronic Obstructive Pulmonary Disease (COPD), or other chronic respiratory disorder (excluding mild asthma requiring occasional inhaler use)?	☐	☐
d. Lupus (SLE), Muscular Dystrophy, Multiple Sclerosis, or other neuromuscular disorder?	☐	☐
e. Diabetes requiring medication other than insulin?	☐	☐
29. During the past 24 months, have you had a suspended or revoked driver's license or had 3 or more moving violations?	☐	☐

APPLICATION FOR LIFE INSURANCE - Part 1

GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY ("GPM Life")

2211 N.E. LOOP 410, San Antonio, Texas 78217 • Telephone: (800) 929-4765 (210) 357-2222

www.gpmlife.com

For Ages 20 through 49, Age Last Birthday

Mail Policy to:
❑ Agent
❑ Policyholder

1.Name of Proposed Insured (First, M.I., Last)

2. Sex ❑ Male ❑ Female | 3.Birthdate | 4.Birthplace

5. US Citizen ❑ Yes ❑ No | 6.Social Security # | 7. Height | 8. Weight

9. Home Address of Proposed Insured | City | State/Country | Zip | Telephone Number

Best time to call _____ A.M. _____ P.M. | Time Zone: ❑ Eastern ❑ Central ❑ Mountain ❑ Pacific

10. Policy: ❑ SECURE-Mark 4 - WL ❑ SECURE-Mark 4 - GDB
(WL Only) ❑ Accidental Death Benefit - ADB
(WL Only) ❑ $5,000 Child Insurance Rider - CIR (Part 2 Required)

11. Amount Applied for:$

12. Premium Amount: $

13. Premium Mode ❑ Annual ❑ SemiAnnual ❑ Monthly EFT

14. Automatic Premium Loan (if available) ❑ Yes ❑ No

15. Beneficiary | Social Security # | Relationship
Primary _____
Contingent

16. Proposed Insured's Occupation

17. Owner/Applicant, if other than the Proposed Insured:

Name _____ Social Security # _____ Relationship to Proposed Insured _____ DOB _____

Address:

18. Physician(s) name, address and phone number: _____

19. a. List Life insurance in force on Proposed Insured: Company _____ Issue Year _____ ADB _____

b. Will the policy applied for replace or change any existing life or annuity policy or contract in any company? ❑ Yes ❑ No

20. Has the Proposed Insured used tobacco in any form in the past 12 months? ❑ Yes ❑ No

If questions 21 through 28 are correctly answered "No", the Proposed Insured may be eligible for SECURE-Mark 4 – WL (Whole Life, Full Death Benefit)

	YES	NO
21. a. Is the Proposed Insured currently hospitalized, confined to a nursing home or hospice, receiving or been recommended to receive home health care, kidney dialysis, or oxygen?	❑	❑
b. Has the Proposed Insured ever been diagnosed by a physician as having Congestive Heart Failure or Cardiomyopathy or been told (s)he has less than 12 months to live?	❑	❑
22. In the past 10 years, has the Proposed Insured been diagnosed by or received treatment from a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS); AIDS Related Complex (ARC); or tested positive for the Human Immunodeficiency Virus (HIV), or the antibodies to such virus?	❑	❑
23. Does the Proposed Insured need any assistance performing activities of daily living (ADLs) such as eating, bathing, using the toilet independently dressing, taking medications, or walking independently without the use of supportive devices?	❑	❑
24. During the past 24 months, has the Proposed Insured been treated or given medical advice by a medical professional, including office visits, medications or surgery for:		
a. Stroke, transient ischemic attack (TIA), heart attack, angina, or any procedure to improve circulation to the heart or brain?	❑	❑
b. Organ transplant or recommendation to have an organ transplant?	❑	❑
c. Melanoma, internal cancer, or leukemia?	❑	❑
d. Alzheimer's disease, dementia, Amyotropic Lateral Sclerosis (ALS) or Parkinson's Disease?	❑	❑
e. Emphysema, liver disease, kidney disease, or kidney failure?	❑	❑
f. Alcohol and/or drug abuse?	❑	❑
g. Diabetes requiring insulin or any diabetic complications including diabetic kidney disease, eye disorder, numbness in hands or feet, diabetic coma, insulin shock, or uncontrolled blood sugars?	❑	❑
25. During the past 5 years, has the Proposed Insured been convicted of a felony, been incarcerated, or been on parole or probation for any offense?	❑	❑

Circle each condition resulting in a "Yes" answer for questions 26 through 28.

26. During the past 12 months, has the Proposed Insured:	YES	NO
a. Been admitted to or confined in a hospital two or more times?	❑	❑
b. Been told by a medical professional that (s)he needs a medical procedure, surgery, hospitalization, or nursing facility care that has not yet been completed?	❑	❑
c. Been confined to a nursing facility or received home health care?	❑	❑
27. During the past 24 months, has the Proposed Insured been treated or given medical advice by a medical professional, including office visits, medications or surgery for:		
a. Seizures or other neurological disorder, Major Depression, Schizophrenia, Psychosis, Bipolar Disorder or other psychiatric disorder?	❑	❑
b. Irregular heart rhythm, enlarged heart, or any other heart disorder?	❑	❑
c. Chronic Obstructive Pulmonary Disease (COPD), or other chronic respiratory disorder (excluding mild asthma requiring occasional inhaler use)?	❑	❑
d. Lupus (SLE), Muscular Dystrophy, Multiple Sclerosis, Amyotropic Lateral Sclerosis (ALS) or other neuromuscular disorder?	❑	❑
e. Diabetes requiring medication other than insulin?	❑	❑
28. During the past 24 months, has the Proposed Insured had a suspended or revoked driver's license or had 3 or more moving violations?	❑	❑

For Home Office Endorsements:	Special Instructions/Requests:

AGREEMENT: I have read this application. I understand the questions and my answers, and I represent that all of the information given in it is true, complete, and correctly written. I understand that any misstatements as to the health or physical condition of the Proposed Insured that are material to the risk assumed may cause any policy issued to become void within the contestable ~~and suicide period. It is agreed that:~~

~~A. This application~~ and any amendments or supplements to it will be relied on by GPM Life as the basis of any policy which may be issued. The signer(s) agree that a complete faxed copy of this document is equivalent to the original.

B. Acceptance of a policy issued on this application will ratify any changes which may be noted in the section for "Home Office Endorsements." Written consent must be obtained for any change in the application, where required by law.

C. Any policy issued by GPM Life, or applied for, shall not take effect unless the full first premium is paid and the policy is delivered to the owner during the lifetime of the Proposed Insured, and all the statements and answers given in the application continue to be true and ~~complete to the best of the Proposed Insured's and Owner's/Applicant's (if other than Proposed Insured) knowledge and belief.~~ The Proposed Insured and Owner/Applicant must notify GPM Life of any material change in health or other risk factors taking place before policy delivery.

D. NO AGENT, BROKER OR MEDICAL EXAMINER IS AUTHORIZED TO ACCEPT RISKS OR PASS UPON INSURABILITY, TO MAKE OR MODIFY CONTRACTS, OR TO WAIVE ANY OF GPM LIFE'S RIGHTS, CONDITIONS, OR REQUIREMENTS. ONLY AN AUTHORIZED OFFICER OF GPM LIFE CAN DO THESE THINGS.

BACKUP WITHHOLDING CERTIFICATION: (required to comply with Federal tax law): Under penalties of perjury, I (the proposed owner) certify that (A) my Social Security (Taxpayer Identification) number as shown in the Application is correct, and (B) I am not subject to backup withholding either because I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report interest or dividends, or the IRS has notified me that I am no longer subject to backup withholding. (NOTE: You must cross out item B above if you have been notified by the IRS that you are currently subject to backup withholding.)

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION: I authorize any medical practitioner, hospital, clinic, mental health facility, facility for the treatment of alcohol, drug abuse, or AIDS, Veteran's Administration hospital, other medically related facility, employer, insurer, or its agent, reinsurer, the Medical Information Bureau, Inc. (MIB), government or law enforcement unit, consumer reporting agency, or other insurance support organization having information as to the mental or physical health, occupation, avocation, other insurance, character, habits, driving record, finances, or age of me, to give such information to GPM Life or its reinsurer(s) at any time, including after my death. I further authorize all said sources, except MIB, to give such information to any agent or insurance support organization acting for GPM Life or its reinsurer(s). Any information obtained will be used to determine eligibility for insurance coverage and benefits, and may be released by GPM Life to its reinsurer(s), the MIB, or other persons or organizations performing business or legal services in connection with my application or claim, or as may be otherwise lawfully required. I agree that a photocopy of this form will be as valid as the original. I also agree that this form will be valid for (1) ~~30~~ months from the date signed in connection with an application for issuance, reinstatement, or change of an insurance policy, or (2) the duration of a claim for benefits. I know that I, or a person authorized to act for me, may obtain a copy of this form. I acknowledge receipt of notices entitled "Information Practices" and "Medical Information Bureau, Inc." from GPM Life.

WARNING: Any person who knowingly and with the intent to defraud any insurance company, or other person, files an application for insurance or settlement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Proposed Insured's Signature X	Date	City & State Where Application Completed
Owner's/Applicant's Signature (If other than Proposed Insured) X	Date	City & State Where Application Completed

AGENT'S STATEMENT: I HEREBY CERTIFY that the answers given to the foregoing questions in this application are full, complete and true to the best of my knowledge and belief; that I know of no condition affecting the insurability of the Proposed Insured which is not fully set forth herein; that I carefully asked each question as written before recording each answer prior to the application being signed; that the Special Notices regarding Information Practices and the Medical Information Bureau, Inc. were given to the Proposed Insured. I further certify that I have interviewed the Proposed Insured face to face and witnessed the above signature(s): ☐ ~~Photo ID verified Type of ID~~ _____

To the best of your knowledge:	Yes	No
A. Has the Proposed Insured any existing life insurance or annuity policy or contract?	☐	☐
B. Is the insurance applied for intended to replace or change any existing life insurance or annuity policy or contract?	☐	☐

If the answer to A or B is "Yes", attach completed replacement forms if required by your state.

X Writing Agent's Signature	Date	Agent's Name (Please Print)	State / License #	GPM Life Agent #
			/	

For Home Office Endorsements:	Special Instructions/Requests:

AGREEMENT: I have read this application. I understand the questions and my answers, and I represent that all of the information given in it is true, complete, and correctly written. I understand that any misstatements as to the health or physical condition of the Proposed Insured that are material to the risk assumed may cause any policy issued to become void within the contestable period. It is agreed that:

A. This application, Part 2 of this application if applicable, and any amendments or supplements to it will be relied on by GPM Life as the basis of any policy which may be issued. The signer(s) agree that a complete faxed copy of this document is equivalent to the original.

B. Acceptance of a policy issued on this application will ratify any changes which may be noted in the section for "Home Office Endorsements." Written consent must be obtained for any change in the application, where required by law.

C. Any policy issued by GPM Life, or applied for, shall not take effect unless the full first premium is paid and the policy is delivered to the owner during the lifetime of the Proposed Insured, and all the statements and answers given in the application continue to be true and complete. The Proposed Insured and Owner/Applicant must notify GPM Life of any material change in health or other risk factors taking place before policy delivery.

D. NO AGENT, BROKER OR MEDICAL EXAMINER IS AUTHORIZED TO ACCEPT RISKS OR PASS UPON INSURABILITY, TO MAKE OR MODIFY CONTRACTS, OR TO WAIVE ANY OF GPM LIFE'S RIGHTS, CONDITIONS, OR REQUIREMENTS. ONLY AN AUTHORIZED OFFICER OF GPM LIFE CAN DO THESE THINGS.

BACKUP WITHHOLDING CERTIFICATION: (required to comply with Federal tax law): Under penalties of perjury, I (the proposed owner) certify that (A) my Social Security (Taxpayer Identification) number as shown in the Application is correct, and (B) I am not subject to backup withholding either because I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report interest or dividends, or the IRS has notified me that I am no longer subject to backup withholding. (NOTE: You must cross out item B above if you have been notified by the IRS that you are currently subject to backup withholding.)

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION: I authorize any medical practitioner, hospital, clinic, mental health facility, facility for the treatment of alcohol, drug abuse, or AIDS, Veteran's Administration hospital, other medically related facility, employer, insurer, or its agent, reinsurer, the Medical Information Bureau, Inc. (MIB), government or law enforcement unit, consumer reporting agency, or other insurance support organization having information as to the mental or physical health, occupation, avocation, other insurance, character, habits, driving record, finances, or age of me, to give such information to GPM Life or its reinsurer(s) at any time, including after my death. I further authorize all said sources, except MIB, to give such information to any agent or insurance support organization acting for GPM Life or its reinsurer(s). Any information obtained will be used to determine eligibility for insurance coverage and benefits, and may be released by GPM Life to its reinsurer(s), the MIB, or other persons or organizations performing business or legal services in connection with my application or claim, or as may be otherwise lawfully required. I agree that a photocopy of this form will be as valid as the original. I also agree that this form will be valid for (1) 24 months from the date signed in connection with an application for issuance, reinstatement, or change of an insurance policy, or (2) the duration of a claim for benefits. I know that I, or a person authorized to act for me, may obtain a copy of this form. I acknowledge receipt of notices entitled "Information Practices" and "Medical Information Bureau, Inc." from GPM Life.

WARNING: Any person who knowingly and with the intent to defraud any insurance company, or other person, files an application for insurance or settlement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Proposed Insured's Signature X	Date	City & State Where Application Completed
Owner's/Applicant's Signature (If other than Proposed Insured) X	Date	City & State Where Application Completed

AGENT'S STATEMENT: I HEREBY CERTIFY that the answers given to the foregoing questions in this application are full, complete and true to the best of my knowledge and belief; that I know of no condition affecting the insurability of the Proposed Insured which is not fully set forth herein; that I carefully asked each question as written before recording each answer prior to the application being signed; that the Special Notices regarding Information Practices and the Medical Information Bureau, Inc. were given to the Proposed Insured. I further certify that I have interviewed the Proposed Insured face to face and witnessed the above signature(s): ❑ Photo ID verified Type of ID _____ (REQUIRED)

To the best of your knowledge:	Yes	No
A. Has the Proposed Insured any existing life insurance or annuity policy or contract?	❑	❑
B. Is the insurance applied for intended to replace or change any existing life insurance or annuity policy or contract?	❑	❑

If the answer to A or B is "Yes", attach completed replacement forms if required by your state.

X

Writing Agent's Signature	Date	Agent's Name (Please Print)	State / License #	GPM Life Agent #
			/	

RECEIPT FOR PAYMENT

Received from _____ Date _____

the sum of $ _____. The payment is received subject to the conditions below. This receipt does not provide any insurance.

I certify that I have explained all of the terms of this receipt to the Owner(s)/Applicant(s), and Proposed Insured, if different.

_____

Signature of Writing Agent

ALL CHECKS MUST BE MADE PAYABLE TO GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY

This receipt is not valid unless it is signed by an agent of GPM Life. This receipt is not valid unless the amount paid with the application, if paid by check or draft, is honored on first presentation for payment. Any policy issued by GPM Life shall not take effect until the full first premium is paid, the policy is delivered to the owner during the lifetime of the Proposed Insured, the effective date of the policy has arrived, and all the statements and answers given in the application continue to be true and complete. The Proposed Insured and Owner/Applicant must notify GPM Life of any material change in health or other risk factors taking place before policy delivery.

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NOTICE OF INFORMATION PRACTICES AND NOTICE REGARDING MEDICAL INFORMATION BUREAU, INC.

WRITING AGENT: This special notice must be detached and given to the Proposed Insured.

PROPOSED INSURED: PLEASE RETAIN THIS SPECIAL NOTICE FOR YOUR RECORDS.

INFORMATION PRACTICES: In most cases, the application is the only source of information required about the person(s) proposed for insurance. Occasionally, it is necessary to collect additional, personal information from other sources. Such information may, in some circumstances, be disclosed to third parties without your specific authorization, but only for certain limited purposes which we deem necessary to the conduct of our business. A right of access and correction exists with respect to any personal information we may collect. A notice providing a more detailed description of our information practices and your rights is available upon request.

GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY ~~•~~ San Antonio, Texas 78265

MEDICAL INFORMATION BUREAU, INC: Information regarding your insurability will be treated as confidential. We, or our reinsurer(s), may, however, make a brief report thereon to the Medical Information Bureau, Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is ~~Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.~~ We, or our reinsurer(s), may also release information in our file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits is submitted.

RECEIPT FOR PAYMENT

Received from _____ Date _____

the sum of $ _____. The payment is received subject to the conditions below. This receipt does not provide any insurance.

I certify that I have explained all of the terms of this receipt to the Owner(s)/Applicant(s), and Proposed Insured, if different.

_____
Signature of Writing Agent

ALL CHECKS MUST BE MADE PAYABLE TO GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY

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GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY • San Antonio, Texas 78265

MEDICAL INFORMATION BUREAU, INC: Information regarding your insurability will be treated as confidential. We, or our reinsurer(s), may, however, make a brief report thereon to the Medical Information Bureau, Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its file.
Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734, telephone number (617) 426-3660. Information for consumers about MIB may be obtained on its website at www.mib.com. We, or our reinsurer(s), may also release information in our file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits is submitted.

Text Comparison

Documents Compared

SM450AR.pdf - Adobe Acrobat Professional

SM45MAR10.pdf

Summary

606 word(s) added
449 word(s) deleted
1853 word(s) matched
32 block(s) matched

To see where the changes are, scroll down.

APPLICATION FOR LIFE INSURANCE

GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY ("GPM Life")
2211 N.E. LOOP 410, San Antonio, Texas 78217
Telephone: (800) 929-4765 (210) 357-2222
www.gpmlife.com

Mail Policy to:
☐ Agent
☐ Policyholder

For Ages 50 through 85, Age Last Birthday

1.Name of Proposed Insured (First, M.I., Last)	2. Sex ☐ Male ☐ Female	3.Birthdate	4.Birthplace	5. US Citizen ☐ Yes ☐ No	6.Social Security #	7. Height	8. Weight

9. Home Address of Proposed Insured City State/Country Zip Telephone Number

Best time to call _____ A.M. _____ P.M. Time Zone: ☐ Eastern ☐ Central ☐ Mountain ☐ Pacific

10. Policy: ☐ SECURE-Mark 4 - WL	11. Amount Applied for: $	12. Premium Amount $	13. Premium Mode ☐ Annual ☐ SemiAnnual ☐ Monthly EFT	14. Automatic Premium Loan (if available) ☐ Yes ☐ No

15. Beneficiary Social Security # Relationship
Primary _____
Contingent

16. Occupation

17. Owner/Applicant, if other than the Proposed Insured:
Name _____ Social Security # _____ Relationship to Proposed Insured _____ DOB _____
Address:

18. Physician(s) name, address and phone number: _____

19. a. List Life insurance in force on Proposed Insured: Company _____ Issue Year _____ ADB _____
b. Will the policy you are applying for replace or change any existing life or annuity policy or contract in any company? ☐ Yes ☐ No
20. Have you used tobacco in any form in the past 12 months? ☐ Yes ☐ No

If questions 21 through 27 are correctly answered "No", the Proposed Insured is eligible for SECURE Mark 4 - WL (Whole Life, Full Death Benefit).

	YES	NO
21. a. Are you currently hospitalized, confined to a nursing home or hospice, receiving or been recommended to receive home health care, kidney dialysis, or oxygen?	☐	☐
b. Have you ever: been diagnosed by a physician as having Congestive Heart Failure or cardiomyopathy, Alzheimer's Disease or dementia, or been told you have less than 12 months to live?	☐	☐
22. In the past 10 years, have you been diagnosed by or received treatment from a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS); AIDS Related Complex (ARC); or tested positive for the Human Immunodeficiency Virus (HIV), or the antibodies to such virus?	☐	☐
23. Do you need any assistance performing activities of daily living (ADLs) such as eating, bathing, using the toilet independently, dressing, taking medications, or walking independently without the use of supportive devices?	☐	☐
24. During the past 5 years, have you been convicted of a felony?	☐	☐
Circle each condition resulting in a "Yes" answer for questions 25 through 27.		
25. During the past 12 months, have you:		
a. Been admitted to or confined in a hospital two or more times?	☐	☐
b. Been told by a medical professional that you need a medical procedure, surgery, hospitalization or nursing facility care?	☐	☐
c. Been confined to a nursing facility or received home health care?	☐	☐
26. During the past 24 months, have you had or been treated by a medical professional, including office visits, medications or surgery for:		
a. Stroke, transient ischemic attack (TIA), heart attack, angina, or any procedure to improve circulation to the heart or brain?	☐	☐
b. Organ transplant, or recommendation to have an organ transplant?	☐	☐
c. Melanoma, internal cancer, or leukemia?	☐	☐
d. Parkinson's Disease, seizure, neurological disorder, depression or other psychiatric disorder?	☐	☐
e. Liver disease, kidney disease, kidney failure or Lupus (SLE)?	☐	☐
f. Irregular heart rhythm, enlarged heart, or any other heart disorder?	☐	☐
g. Alcohol and/or drug abuse?	☐	☐
h. Diabetes requiring more than 80 units of insulin, or any diabetic complications, including diabetic kidney disease, eye disorder, numbness in hands or feet, diabetic coma, insulin shock, or uncontrolled blood sugars?	☐	☐
i. Emphysema, Chronic Obstructive Pulmonary Disease (COPD), or other chronic respiratory disorder (excluding mild asthma requiring occasional inhaler use)?	☐	☐
27. During the past 24 months, have you had a suspended or revoked driver's license or had 3 or more moving violations?	☐	☐

APPLICATION FOR LIFE INSURANCE - Part 1

GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY ("GPM Life")
2211 N.E. LOOP 410, San Antonio, Texas 78217 • Telephone: (800) 929-4765 (210) 357-2222
www.gpmlife.com

For Ages 50 through 85, Age Last Birthday

Mail Policy to:
❑ Agent
❑ Policyholder

1.Name of Proposed Insured (First, M.I., Last)

2. Sex ❑ Male ❑ Female | 3.Birthdate | 4.Birthplace

5. US Citizen ❑ Yes ❑ No | 6.Social Security # | 7. Height | 8. Weight

9. Home Address of Proposed Insured | City | State/Country | Zip | Telephone Number

Best time to call _____ A.M. _____ P.M. | Time Zone: ❑ Eastern ❑ Central ❑ Mountain ❑ Pacific

10. Policy: ❑ SECURE-Mark 4 - WL ❑ SECURE-Mark 4 - GDB ❑ SECURE-Mark 4 - MBWL
(WL Only) ❑ Accidental Death Benefit - ADB
(WL Only) ❑ $5,000 Child Insurance Rider - CIR (Part 2 Required)

11. Amount Applied for:$

12. Premium Amount: $

13. Premium Mode ❑ Annual ❑ SemiAnnual ❑ Monthly EFT

14. Automatic Premium Loan (if available) ❑ Yes ❑ No

15. Beneficiary | Social Security # | Relationship
Primary _____
Contingent

16. Proposed Insured's Occupation

17. Owner/Applicant, if other than the Proposed Insured:

Name _____ Social Security # _____ Relationship to Proposed Insured _____ DOB _____

Address:

18. Physician(s) name, address and phone number: _____

19. a. List Life insurance in force on Proposed Insured: Company _____ Issue Year _____ ADB _____
b. Will the policy applied for replace or change any existing life or annuity policy or contract in any company? ❑ Yes ❑ No

20. Has the Proposed Insured used tobacco in any form in the past 12 months? ❑ Yes ❑ No

If questions 21 through 29 are correctly answered "No", the Proposed Insured may be eligible for SECURE-Mark 4 - WL (Whole Life, Full Death Benefit).

	YES	NO
21. Is the Proposed Insured currently hospitalized, confined to a nursing home or hospice, receiving or been recommended to receive home health care or kidney dialysis, or been diagnosed by a physician as having Alzheimer's Disease, dementia, or Amyotropic Lateral Sclerosis (ALS) or been told (s)he have less than 12 months to live?	❑	❑
22. In the past 10 years, has the Proposed Insured been diagnosed by or received treatment from a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS); AIDS Related Complex (ARC); or tested positive for the Human Immunodeficiency Virus (HIV), or the antibodies to such virus?	❑	❑
23. During the past 5 years, has the Proposed Insured been convicted of a felony, been incarcerated, or been on parole or probation for any offense?	❑	❑
24. Is the Proposed Insured currently receiving or been recommended to receive oxygen?	❑	❑
25. Has the Proposed Insured ever been diagnosed by a physician as having Congestive Heart Failure or cardiomyopathy?	❑	❑
26. Does the Proposed Insured need any assistance performing activities of daily living (ADLs) such as eating, bathing, using the toilet independently, dressing, taking medications, or walking independently without the use of supportive devices?	❑	❑

Circle each condition resulting in a "Yes" answer for questions 27 through 29.

27. During the past 12 months, has the Proposed Insured:

a. Been admitted to or confined in a hospital two or more times?	❑	❑
b. Been told by a medical professional that (s)he needs a medical procedure, surgery, hospitalization or nursing facility care that has not been completed?	❑	❑
c. Been confined to a nursing facility or received home health care?	❑	❑

	YES	NO
28. During the past 24 months, has the Proposed Insured been treated or given medical advice by a medical professional, including office visits, medications or surgery for:		
a. Stroke, transient ischemic attack (TIA), heart attack, angina, or any procedure to improve circulation to the heart or brain?	❑	❑
b. Organ transplant, or recommendation to have an organ transplant?	❑	❑
c. Melanoma, internal cancer, or leukemia?	❑	❑
d. Parkinson's Disease, seizure, neurological disorder, Major Depression, Schizophrenia, Psychosis, Bipolar Disorder, or other psychiatric disorder?	❑	❑
e. Liver disease, kidney disease, kidney failure, Lupus (SLE) or Amyotropic Lateral Sclerosis (ALS)?	❑	❑
f. Irregular heart rhythm, enlarged heart, or any other heart disorder?	❑	❑
g. Alcohol and/or drug abuse?	❑	❑
h. Diabetes requiring more than 80 units of insulin, or any diabetic complications, including diabetic kidney disease, eye disorder, numbness in hands or feet, diabetic coma, insulin shock, or uncontrolled blood sugars?	❑	❑
i. Emphysema, Chronic Obstructive Pulmonary Disease (COPD), or other chronic respiratory disorder (excluding mild asthma requiring occasional inhaler use)?	❑	❑
29. During the past 24 months, has the Proposed Insured had a suspended or revoked driver's license or had 3 or more moving violations?	❑	❑

For Home Office Endorsements:	Special Instructions/Requests:

AGREEMENT: I have read this application. I understand the questions and my answers, and I represent that all of the information given in it is true, complete, and correctly written. I understand that any misstatements as to the health or physical condition of the Proposed Insured that are material to the risk assumed may cause any policy issued to become void within the contestable ~~and suicide period. It is agreed that:~~

~~A. This application~~ and any amendments or supplements to it will be relied on by GPM Life as the basis of any policy which may be issued. The signer(s) agree that a complete faxed copy of this document is equivalent to the original.

B. Acceptance of a policy issued on this application will ratify any changes which may be noted in the section for "Home Office Endorsements." Written consent must be obtained for any change in the application, where required by law.

C. Any policy issued by GPM Life, or applied for, shall not take effect unless the full first premium is paid and the policy is delivered to the owner during the lifetime of the Proposed Insured, and all the statements and answers given in the application continue to be true and ~~complete to the best of the Proposed Insured's and Owner's/Applicant's (if other than Proposed Insured) knowledge and belief.~~ The Proposed Insured and Owner/Applicant must notify GPM Life of any material change in health or other risk factors taking place before policy delivery.

D. NO AGENT, BROKER OR MEDICAL EXAMINER IS AUTHORIZED TO ACCEPT RISKS OR PASS UPON INSURABILITY, TO MAKE OR MODIFY CONTRACTS, OR TO WAIVE ANY OF GPM LIFE'S RIGHTS, CONDITIONS, OR REQUIREMENTS. ONLY AN AUTHORIZED OFFICER OF GPM LIFE CAN DO THESE THINGS.

BACKUP WITHHOLDING CERTIFICATION: (required to comply with Federal tax law): Under penalties of perjury, I (the proposed owner) certify that (A) my Social Security (Taxpayer Identification) number as shown in the Application is correct, and (B) I am not subject to backup withholding either because I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report interest or dividends, or the IRS has notified me that I am no longer subject to backup withholding. (NOTE: You must cross out item B above if you have been notified by the IRS that you are currently subject to backup withholding.)

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION: I authorize any medical practitioner, hospital, clinic, mental health facility, facility for the treatment of alcohol, drug abuse, or AIDS, Veteran's Administration hospital, other medically related facility, employer, insurer, or its agent, reinsurer, the Medical Information Bureau, Inc. (MIB), government or law enforcement unit, consumer reporting agency, or other insurance support organization having information as to the mental or physical health, occupation, avocation, other insurance, character, habits, driving record, finances, or age of me, to give such information to GPM Life or its reinsurer(s) at any time, including after my death. I further authorize all said sources, except MIB, to give such information to any agent or insurance support organization acting for GPM Life or its reinsurer(s). Any information obtained will be used to determine eligibility for insurance coverage and benefits, and may be released by GPM Life to its reinsurer(s), the MIB, or other persons or organizations performing business or legal services in connection with my application or claim, or as may be otherwise lawfully required. I agree that a photocopy of this form will be as valid as the original. I also agree that this form will be valid for (1) ~~30~~ months from the date signed in connection with an application for issuance, reinstatement, or change of an insurance policy, or (2) the duration of a claim for benefits. I know that I, or a person authorized to act for me, may obtain a copy of this form. I acknowledge receipt of notices entitled "Information Practices" and "Medical Information Bureau, Inc." from GPM Life.

WARNING: Any person who knowingly and with the intent to defraud any insurance company, or other person, files an application for insurance or settlement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Proposed Insured's Signature X	Date	City & State Where Application Completed
Owner's/Applicant's Signature (If other than Proposed Insured) X	Date	City & State Where Application Completed

AGENT'S STATEMENT: I HEREBY CERTIFY that the answers given to the foregoing questions in this application are full, complete and true to the best of my knowledge and belief; that I know of no condition affecting the insurability of the Proposed Insured which is not fully set forth herein; that I carefully asked each question as written before recording each answer prior to the application being signed; that the Special Notices regarding Information Practices and the Medical Information Bureau, Inc. were given to the Proposed Insured. I further certify that I have interviewed the Proposed Insured face to face and witnessed the above signature(s): ☐ ~~Photo ID verified Type of ID~~ _____

To the best of your knowledge:	Yes	No
A. Has the Proposed Insured any existing life insurance or annuity policy or contract?	☐	☐
B. Is the insurance applied for intended to replace or change any existing life insurance or annuity policy or contract?	☐	☐

If the answer to A or B is "Yes", attach completed replacement forms if required by your state.

X Writing Agent's Signature	Date	Agent's Name (Please Print)	/ State / License #	GPM Life Agent #

For Home Office Endorsements:	Special Instructions/Requests:

AGREEMENT: I have read this application. I understand the questions and my answers, and I represent that all of the information given in it is true, complete, and correctly written. I understand that any misstatements as to the health or physical condition of the Proposed Insured that are material to the risk assumed may cause any policy issued to become void within the contestable period. It is agreed that:

A. This application, Part 2 of this application if applicable, and any amendments or supplements to it will be relied on by GPM Life as the basis of any policy which may be issued. The signer(s) agree that a complete faxed copy of this document is equivalent to the original.

B. Acceptance of a policy issued on this application will ratify any changes which may be noted in the section for "Home Office Endorsements." Written consent must be obtained for any change in the application, where required by law.

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BACKUP WITHHOLDING CERTIFICATION: (required to comply with Federal tax law): Under penalties of perjury, I (the proposed owner) certify that (A) my Social Security (Taxpayer Identification) number as shown in the Application is correct, and (B) I am not subject to backup withholding either because I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report interest or dividends, or the IRS has notified me that I am no longer subject to backup withholding. (NOTE: You must cross out item B above if you have been notified by the IRS that you are currently subject to backup withholding.)

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION: I authorize any medical practitioner, hospital, clinic, mental health facility, facility for the treatment of alcohol, drug abuse, or AIDS, Veteran's Administration hospital, other medically related facility, employer, insurer, or its agent, reinsurer, the Medical Information Bureau, Inc. (MIB), government or law enforcement unit, consumer reporting agency, or other insurance support organization having information as to the mental or physical health, occupation, avocation, other insurance, character, habits, driving record, finances, or age of me, to give such information to GPM Life or its reinsurer(s) at any time, including after my death. I further authorize all said sources, except MIB, to give such information to any agent or insurance support organization acting for GPM Life or its reinsurer(s). Any information obtained will be used to determine eligibility for insurance coverage and benefits, and may be released by GPM Life to its reinsurer(s), the MIB, or other persons or organizations performing business or legal services in connection with my application or claim, or as may be otherwise lawfully required. I agree that a photocopy of this form will be as valid as the original. I also agree that this form will be valid for (1) 24 months from the date signed in connection with an application for issuance, reinstatement, or change of an insurance policy, or (2) the duration of a claim for benefits. I know that I, or a person authorized to act for me, may obtain a copy of this form. I acknowledge receipt of notices entitled "Information Practices" and "Medical Information Bureau, Inc." from GPM Life.

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Proposed Insured's Signature X	Date	City & State Where Application Completed
Owner's/Applicant's Signature (If other than Proposed Insured) X	Date	City & State Where Application Completed

AGENT'S STATEMENT: I HEREBY CERTIFY that the answers given to the foregoing questions in this application are full, complete and true to the best of my knowledge and belief; that I know of no condition affecting the insurability of the Proposed Insured which is not fully set forth herein; that I carefully asked each question as written before recording each answer prior to the application being signed; that the Special Notices regarding Information Practices and the Medical Information Bureau, Inc. were given to the Proposed Insured. I further certify that I have interviewed the Proposed Insured face to face and witnessed the above signature(s): ❑ Photo ID verified Type of ID _____ (REQUIRED)

To the best of your knowledge:	Yes	No
A. Has the Proposed Insured any existing life insurance or annuity policy or contract?	❑	❑
B. Is the insurance applied for intended to replace or change any existing life insurance or annuity policy or contract?	❑	❑

If the answer to A or B is "Yes", attach completed replacement forms if required by your state.

X Writing Agent's Signature	Date	Agent's Name (Please Print)	State / License #	GPM Life Agent #
			/	

RECEIPT FOR PAYMENT

Received from _____ Date _____

the sum of $ _____. The payment is received subject to the conditions below. This receipt does not provide any insurance.

I certify that I have explained all of the terms of this receipt to the Owner(s)/Applicant(s), and Proposed Insured, if different.

_____

Signature of Writing Agent

ALL CHECKS MUST BE MADE PAYABLE TO GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY

This receipt is not valid unless it is signed by an agent of GPM Life. This receipt is not valid unless the amount paid with the application, if paid by check or draft, is honored on first presentation for payment. Any policy issued by GPM Life shall not take effect until the full first premium is paid, the policy is delivered to the owner during the lifetime of the Proposed Insured, the effective date of the policy has arrived, and all the statements and answers given in the application continue to be true and complete. The Proposed Insured and Owner/Applicant must notify GPM Life of any material change in health or other risk factors taking place before policy delivery.

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NOTICE OF INFORMATION PRACTICES AND NOTICE REGARDING MEDICAL INFORMATION BUREAU, INC.

WRITING AGENT: This special notice must be detached and given to the Proposed Insured.

PROPOSED INSURED: PLEASE RETAIN THIS SPECIAL NOTICE FOR YOUR RECORDS.

INFORMATION PRACTICES: In most cases, the application is the only source of information required about the person(s) proposed for insurance. Occasionally, it is necessary to collect additional, personal information from other sources. Such information may, in some circumstances, be disclosed to third parties without your specific authorization, but only for certain limited purposes which we deem necessary to the conduct of our business. A right of access and correction exists with respect to any personal information we may collect. A notice providing a more detailed description of our information practices and your rights is available upon request.

GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY ~~-~~ San Antonio, Texas 78265

MEDICAL INFORMATION BUREAU, INC: Information regarding your insurability will be treated as confidential. We, or our reinsurer(s), may, however, make a brief report thereon to the Medical Information Bureau, Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is ~~Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.~~ We, or our reinsurer(s), may also release information in our file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits is submitted.

RECEIPT FOR PAYMENT

Received from _____ Date _____

the sum of $ _____. The payment is received subject to the conditions below. This receipt does not provide any insurance.

I certify that I have explained all of the terms of this receipt to the Owner(s)/Applicant(s), and Proposed Insured, if different.

_____
Signature of Writing Agent

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GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY • San Antonio, Texas 78265

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Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734, telephone number (617) 426-3660. Information for consumers about MIB may be obtained on its website at www.mib.com. We, or our reinsurer(s), may also release information in our file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits is submitted.

STATEMENT OF POLICY COST AND BENEFIT INFORMATION - POLICY SUMMARY

Child Insurance Rider

Specimen Copy

Insured on Rider:	John L Doe	**Policy Number:**	000970006
Initial Sum Insured:	$5,000.00	**Rider Effective Date:**	January 1, 2010
State:	TX	**Issue Age:**	4 MALE
Initial Annual Premium:	$15.00	**Plan Code:**	CIR10S
	$1.32 MONTHLY	**Risk Class:**	100%

-------ANNIVERSARY-------- END OF YEAR	AT AGE	IN YEAR	DEATH BENEFIT AT START OF YEAR	GUARANTEED ANNUAL PREMIUM
1	5	2011	$5,000	$15.00
2	6	2012	5,000	15.00
3	7	2013	5,000	15.00
4	8	2014	5,000	15.00
5	9	2015	5,000	15.00
6	10	2016	5,000	15.00
7	11	2017	5,000	15.00
8	12	2018	5,000	15.00
9	13	2019	5,000	15.00
10	14	2020	5,000	15.00
11	15	2021	5,000	15.00
12	16	2022	5,000	15.00
13	17	2023	5,000	15.00
14	18	2024	5,000	15.00
15	19	2025	5,000	15.00
16	20	2026	5,000	15.00
17	21	2027	5,000	15.00
18	22	2028	5,000	15.00
19	23	2029	5,000	15.00
20	24	2030	5,000	15.00
21	25	2031	5,000	15.00

This statement provides general information about the optional rider identified above. For similar information about the basic plan, optional riders or supplemental benefits of the policy, refer to attached statements. Refer to provisions of the policy for answers to specific questions regarding premiums, benefits, and options.

Continued on back of page

THIS IS AN ILLUSTRATION ONLY. AN ILLUSTRATION IS NOT INTENDED TO PREDICT ACTUAL PERFORMANCE. INTEREST RATES, DIVIDENDS, AND VALUES SET FORTH IN THE ILLUSTRATION ARE NOT GUARANTEED EXCEPT FOR THOSE ITEMS CLEARLY LABELED AS GUARANTEED.

Prepared on: 1/14/2010

STATEMENT OF POLICY COST AND BENEFIT INFORMATION - POLICY SUMMARY

Child Insurance Rider

	INSURANCE COVERAGE	INSURED	AGE	INITIAL BENEFIT AMOUNT	INITIAL ANNUAL PREMIUM
CIR10S	Child Insurance Rider	John L Doe	4	5,000	15.00

Life Insurance Interest Adjusted Cost Comparison Indexes per $1,000 (Assumes that the time value of money is 5% per year):

	Guaranteed	
	10 Year	20 Year
Surrender Cost Comparison Index	$ 3.00	$ 3.00
Net Payment Cost Comparison Index	3.00	3.00
Equivalent Level Annual Dividend	N/A	N/A

An explanation of the intended use of these indexes is included in the Life Insurance Buyers Guide.

Any Questions -- Please contact your agent or the Home Office.

Agent: 00025 Home Office
PO Box 659567
San Antonio TX 78265-9567

Phone:

Prepared on: 1/14/2010 000970006

Specimen Simplified Issue Whole Life Schedule Page with Accidental Death Benefit Rider.

SCHEDULE PAGE

PLAN	COVERAGE DESCRIPTION	INITIAL SUM INSURED	POLICY CLASS	ANNUAL PREMIUM	BENEFIT CEASES
SIWL07	Simplified Issue Whole Life Insurance Policy	$25,000	100% Standard No Tobacco	$405.00	2075
ADB10S	Accidental Death Benefit Rider	$25,000	100%	$35.25	2045

POLICY NUMBER:

000970007

POLICY DATE:

January 1, 2010

NAME OF INSURED:

John Doe

AGE AT ISSUE/SEX:

35 MALE

ANNUAL PREMIUM:

$440.25

Semi-Annual Premium
$233.43

Special Monthly
$38.60

Electronic Funds Transfer
$38.60 Monthly

OWNER
John Doe

The owner and beneficiary are as stated in the application unless later changed.

Specimen Simplified Issue Whole Life Schedule Page with Child Insurance Rider.

SCHEDULE PAGE

PLAN	COVERAGE DESCRIPTION	INITIAL SUM INSURED	POLICY CLASS	ANNUAL PREMIUM	BENEFIT CEASES
SIWL07	Simplified Issue Whole Life Insurance Policy	$25,000	100% Standard No Tobacco	$405.00	2075
CIR10S	Child Insurance Rider	$5,000	100%	$15.00	2031
	Insured: John L Doe			Male 04	

POLICY NUMBER:

000970008

POLICY DATE:

January 1, 2010

NAME OF INSURED:

John Doe

AGE AT ISSUE/SEX:

35 MALE

ANNUAL PREMIUM:

$420.00

Semi-Annual Premium
$222.70

Special Monthly
$36.82

Electronic Funds Transfer
$36.82 Monthly

OWNER
John Doe

The owner and beneficiary are as stated in the application unless later changed.

SCHEDULE PAGE

Specimen Simplified Issue Whole Life Schedule Page with Accidental Death Benefit Rider and Child Insurance Rider.

PLAN	COVERAGE DESCRIPTION	INITIAL SUM INSURED	POLICY CLASS	ANNUAL PREMIUM	BENEFIT CEASES
SIWL07	Simplified Issue Whole Life Insurance Policy	$25,000	100% Standard No Tobacco	$405.00	2075
ADB10S	Accidental Death Benefit Rider	$25,000	100%	$35.25	2045
CIR10S	Child Insurance Rider	$5,000	100%	$15.00	2031
	Insured: John L Doe			Male 04	

POLICY NUMBER:

000970006

POLICY DATE:

January 1, 2010

NAME OF INSURED:

John Doe

AGE AT ISSUE/SEX:

35 MALE

ANNUAL PREMIUM:

$455.25

Semi-Annual Premium
$241.38

Special Monthly
$39.92

Electronic Funds Transfer
$39.92 Monthly

OWNER
John Doe

The owner and beneficiary are as stated in the application unless later changed.